Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

MAA's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP.

☞ **Note:** DOH no longer provides training to nurses for EPSDT screenings.

☞ **Note:** Only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

Who is eligible for EPSDT screenings?

MAA covers EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the identifiers listed on the following page:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – CHIP	CNP – State Children's Health Insurance Program
CNP - Emergency Medical Only	CNP - Emergency Medical Only (Covered only when the service is related to the emergent condition.)
LCP – MNP	Limited Casualty Program – Medically Needy Program

☞ **Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

Are clients enrolled in one of MAA's Managed Care plans eligible for EPSDT?

Yes! EPSDT screenings are included in the scope of service provided by MAA's managed care plans. Clients who are enrolled in one of MAA's managed care plans will have an identifier in the HMO column on their DSHS Medical ID card.

Please refer managed care clients to their respective managed care plan's primary care provider (PCP) for coordination of necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

Do not bill MAA for EPSDT services. They are included in the managed care plan's reimbursement.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column on their DSHS Medical ID card will be "PCCM." These clients must obtain or be referred for services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting.

☞ **Note:** To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

Billing for Infants Not Yet Assigned a Patient Identification Code (PIC)

Use the PIC of either parent for a newborn if the infant has not yet been issued a PIC. Enter indicator **B** in the *Comments* section of the claim form to indicate that the parent's PIC is being used for the infant. When using a parent's PIC for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For parents enrolled in an MAA managed care plan, the plan is responsible for providing medical coverage for the newborn.**

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
    - ✓ How to clean teeth as they erupt;
    - ✓ How to prevent baby bottle tooth decay;
    - ✓ How to look for dental disease;
    - ✓ Information on how dental disease is contracted;
    - ✓ Preventive sealant; and
    - ✓ Application of fluoride varnish, when appropriate;
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

Licensed providers may perform these components separately; however, MAA encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening components listed on the previous page:

- Appropriate audiometric tests (CPT codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following is Washington State's schedule for health screening visits:

- Five total screenings during the first year of the infant's life. Below is a recommended screening schedule for children from birth to one year of age.

  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old

- Three screening examinations are required between the ages of 1 and 2 years.
- One screening examination is required per 12-month period for children ages 2 through 6.
- One screening examination is required per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

> ☞ **Note:** If a client is placed in foster care or is placed in the care of a relative, MAA will reimburse providers for an EPSDT screen without regard to the periodicity schedule above.

Foster Care Children

MAA reimburses providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through MAA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

To receive the enhanced rate, providers **must** bill the appropriate EPSDT code with modifier 21 in order to identify foster care clients.

MAA reimburses providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier 21.

☞ **Note:** A child placed outside of the home in the care of a relative does not qualify as a foster care client. However, MAA reimburses providers for an EPSDT screening exam without regard to the periodicity schedule for these clients using MAA's normal maximum allowable fee for EPSDT procedures. Providers must indicate "**EPSDT screen performed for child in relative care**" in the *Comments* section of the claim form.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)] (see Important Contacts section for information on obtaining DSHS forms); **or**
- Another charting tool with equivalent information.

To obtain copies of the Well Child Examination forms:

- Submit a completed Forms and Publications Request form [DSHS # 17-011] to:

  Medical Assistance Administration
  PO Box 45530
  Olympia, WA 98504-5530
  FAX (360) 753-7315

-OR-

- Download an electronic copy of the Well Child Examination forms at: **http://www1.dshs.wa.gov/msa/forms/eforms.html**

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
MAA's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants - within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

EPSDT interperiodic screenings

☞ **Note:** MAA no longer reimburses providers for interperiodic screenings. If a client is seen for a suspected health problem, providers must bill these services using the appropriate level Evaluation & Management (E&M) procedure code, with the ICD-9-CM diagnosis code that accurately describes the sign(s), symptom(s), or condition(s) found. **It is no longer necessary to bill using modifier EP for these services**.

What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate MAA provider or MAA's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

☞ **Note:** If the provider is using the parent's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

Orthodontics
Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions only. MAA does not reimburse for orthodontic treatment for other conditions.

Lead Toxicity Screening
Providers are no longer required to use the Lead Toxicity Screening Risk Factor questionnaire. Health care providers should use clinical judgment when screening for lead toxicity.

Fetal Alcohol Syndrome (FAS) Screening
FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, and/or a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen, every child six months of age or older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or there is suspicion of facial characteristics of FAS or microcephaly.

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

MAA reimburses the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

CPT Procedure Code	Brief Description	Limitations
97802	Medical nutrition, indiv, initial	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	Med nutrition, indiv, subseq	1 unit = 15 minutes; maximum of 1 hour (4 units) per day
97804	Medical nutrition, group	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

Fluoride Varnish (HCPCS code D1203)

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process. It is applied up to three times in a 12-month period to all surfaces of the teeth. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

Who may prescribe the fluoride varnish?

- Dentists;
- Physicians;
- Physician Assistants (PA); or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, age 18 years and younger, may receive fluoride varnish applications. Clients with disabilities age 19 and older are also eligible.

Are managed care clients eligible?

Clients whose DSHS Medical ID cards have an identifier in the HMO column are enrolled in one of MAA's managed health care plans. These clients **are eligible for fluoride varnish applications** through fee-for-service. Bill MAA directly for fluoride varnish applications.

Immunizations - Children

(This applies to clients age 20 years and younger. For clients age 21 years and older, refer to "Immunizations-Adults" on page C.11.)

Immunizations under the EPSDT program are usually given in conjunction with a screening exam. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis that is different from the immunization.

Immunizations covered under the EPSDT program are listed in the vaccine table on page C.10. For children age 18 years and younger, the vaccines that are shaded in the table are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program. MAA does not reimburse providers for these vaccines.

Providers must bill for the administration of the vaccine and for the cost of the vaccine itself as detailed on the following page:

Clients age 18 years and younger – Vaccines that are identified by shading

- These vaccines are available at no cost from DOH. Therefore, MAA reimburses providers for an administration fee only.

- Bill for the administration of the vaccine by reporting the procedure code given with modifier SL (e.g., 90707 SL).

- DO NOT bill CPT codes 90471-90472 or 90465-90468 for the administration of the vaccine.

Clients age 18 years and younger – Vaccines not identified by shading

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with non-shaded vaccines. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.

- ***Do not*** bill any of the codes in the following table in combination with CPT codes 90471-90472. MAA limits reimbursement for immunization administration to a maximum of two vaccines (e.g., one unit of 90465 and one unit of 90466; or one unit of 90467 and one unit of 90468).

CPT Code	Brief Description
90465	Immune admin 1 inj, <8 yrs (may not be billed in conjunction with 90467
90466	Immune admin addl inj, < 8 yrs (must be reported in conjunction with 90465 or 90467)
90467	Immune admin O or N < 8 yrs (may not be reported in conjunction with 90465)
90468	Immune admin O/N, addl < 8 y (must be reported in conjunction with 90465 or 90467

☞ **Note:** MAA reimburses the above administration codes ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill the above administration codes on the **same** claim as the procedure code for the vaccine.

Clients age 19-20 years – All Vaccines

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is shaded or not. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Clarification to Health Departments

Health Departments may bill CPT code 99211 when an immunization is the only service provided.

> **Example:** If a client receives an immunization that is not available free of charge from the Department of Health (DOH), you may bill CPT code 99211, the appropriate immunization administration code(s) (i.e. 90471-90472 or 90465-90468), and the vaccine. If the vaccine was received at no charge from DOH, you may bill 99211 and the appropriate vaccine code with modifier –SL.

Vaccines that are shaded in the table are available at no cost from DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children age 18 years and younger.
MAA does not reimburse providers for these vaccines.

CPT	Vaccine
90585	Bcg vaccine, percut
90586	Bcg vaccine, intravescial
90632	Hep a vaccine, adult im
90633	Hep a vacc, ped/adol, 2 dose
90636	Hep a/Hep B vacc (adult)
90645	Hib vaccine, hboc, im
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90655	Flu vacc split pres free 6-35 months
90656	Flu vacc split pres free 3 years and above
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90660	Flu vacc, nasal (Covered October 1 through March 31 only)
90665	Lyme disease vaccine, im
90669	Pneumococcal vacc, ped<5
90675	Rabies vaccine, im
90676	Rabies vaccine, id
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90700	Dtap vaccine, im
90701	Dtp vaccine, im
90702	Dt vaccine <7, im
90703	Tetanus vaccine, im
90704	Mumps vaccine, sc
90705	Measles vaccine, sc
90706	Rubella vaccine, sc
90707	Mmr vaccine, sc
90708	Measles-rubella vaccine, sc
90709	Rubella & mumpsvaccine, sc
90712	Oral poliovirus vaccine
90713	Poliovirus, ipv, sc
90715	TdaP, 7 years and older, intramuscular
90716	Chicken pox vaccine, sc
90717	Yellow fever vaccine, sc
90718	Td vaccine >7, im
90720	Dtp/hib vaccine, im
90725	Cholera vaccine, injectable
90732	Pneumoccocal vacc, adult/ill
90733	Meningococcal vaccine, sc
90734	Meningococcal vacc, intramuscular
90735	Encephalitis, vaccine, sc
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hep b vacc ped/adol 3 dose, im
90746	Hep b vaccine, adult, im
90747	Hep b vacc, ill pat 4 dose, im
90748	Hep b/hib vaccine, im
90749	Vaccine toxoid

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children")

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, precut	90707	Mmr vaccine, sc
90586	Bcg vaccine, intravesical	90708	Measles-rubella vaccine, sc
90632	Hep a vaccine, adult im	90709	Rubella & mumps vaccine, sc
90636	Hep a/hep b vacc, adult im	90712	Oral poliovirus vaccine
90645	Hib vaccine, hboc, im	90713	Poliovirus, ipv, sc
90646	Hib vaccine, prp-d, im	90715	TdaP, 7 years and older, Intramuscular
90647	Hib vaccine, prp-omp, im		
90648	Hib vaccine, prp-t, im	90716	Chicken pox vaccine, sc
90656	Flu vacc split pres free 3 years and above	90717	Yellow fever vaccine, sc
		90718	Td vaccine >7, im
90658	Flu vaccine, 3 yrs, im	90720	Dtp/hib vaccine, im
90660	Flu vacc, nasal (Covered October 1 through March 31 only)	90725	Cholera vaccine, injectable
		90732	Pneumococcal vacc, adult/ill
90665	Lyme disease vaccine, im	90733	Meningococcal vaccine, sc
90675	Rabies vaccine, im	90734	Meningococcal vacc, intramuscular
90676	Rabies vaccine, id	90735	Encephalitis vaccine, sc
90690	Typhoid vaccine, oral	90740	Hepb vacc, ill pat 3 dose, im
90691	Typhoid vaccine, im	90746	Hep b vaccine, adult, im
90692	Typhoid vaccine, h-p, sc/id	90747	Hepb vacc, ill pat 4 dose, im
90701	Dtp vaccine, im	90748	Hep b/hib vaccine, im
90703	Teanus vaccine, im	90749	Vaccine toxoid
90704	Mumps vaccine, sc		
90706	Rubella vaccine, sc		

Immune Globulins

> ☞ **Note:** MAA does not reimburse immune globulins that are obtained free of charge.

- **RespiGam** – Do not bill CPT code 90379 for RespiGam. You must use HCPCS code J1565.

- **Synagis** (CPT code 90378)

  ✓ Bill one unit for each 50 mg of Synagis used.

  ✓ MAA covers Synagis for those clients 11 months of age and younger from December 1 - April 30 of any given year without prior authorization (PA).

  ✓ PA is required for all other time periods and for all other age groups.

  Requests for authorization must be submitted in writing to:

  MAA-Division of Medical Management
  Attn: Synagis Program
  PO Box 45506
  Olympia, WA 98504-5506
  FAX: (360) 725-2141

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

  ✓ RIG is sold in either 2 ml or 10 ml vials.
  ✓ One dose is allowed per episode.
  ✓ Bill one unit for each 2 ml vial used per episode.

  Examples:

  ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
  ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill MAA for immune globulins using the HCPCS procedure codes listed below. MAA does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

Noncovered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	Q9941 – Q9944
90291	J0850
90379	J1565
90384	J2790
90385	J2790
90386	J2792
90389	J1670

Therapeutic or Diagnostic Injections

(CPT codes 90780-90788, 90799, and HCPCS codes G0345 – G0353)
[Refer to WAC 388-531-0950]

- MAA reimburses providers for injection procedures and/or injectable drug products provided to a client only when the injectable drug used is from office stock purchased by the provider from a pharmacist or drug manufacturer. Providers must not bill MAA for drugs obtained free of charge (e.g. free samples).

- If no other service is performed on the same day, a subcutaneous or intramuscular injection (CPT code 90782 or HCPCS code G0351) or an intramuscular antibiotic injection (CPT code 90788) can be billed in addition to an injectable drug code.

- When a subcutaneous or intramuscular injection (CPT code 90782 or HCPCS code G0351) or an intramuscular antibiotic injection (CPT code 90788) is provided on the same day as an Evaluation & Management (E&M) service, the injections are bundled into the E&M service and are not reimbursed separately.

- Intra-arterial injections (CPT code 90783) and intravenous therapeutic or diagnostic injections (CPT code 90784 or HCPCS code G0353) are reimbursed separately even when provided on the same day as an E&M service. Separate payment for the drug is allowed using the appropriate HCPCS injection drug code. However, these injections are not reimbursed separately if provided in conjunction with IV infusion therapy services (CPT codes 90780 and 90781 or HCPCS codes G0345 – G0349).

- Do not bill CPT codes 90780 – 90788 in combination with HCPCS codes G0345 – G0353. MAA does not reimburse providers for CPT code 99211 on the same date of service as drug administration HCPCS codes G0345 – G0349, G0351 – G0353, and CPT codes 90780 – 90788. If billed in combination, MAA will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable services was provided. If modifier 25 is not utilized, MAA will deny the drug administration code.

Note: Drugs must be billed using the HCPCS drug codes and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review. For billing information and reimbursement of chemotherapy services, see page F.15.

Hyalgan/Synvisc

- MAA reimburses only orthopedic surgeons and rheumatologists for Hyalgan or Synvisc.
- MAA allows a maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.
- This series of injections may be repeated at 12-week intervals.
- Providers must bill for Hyalgan and Synvisc using the following HCPCS codes:

HCPCS Code	Description	Limitations
J7317	Sodium hyaluronate, 20-25 mg, for intra-articular injection (Hyalgan)	Maximum of 5 injections Maximum of 5 units (1 unit = 1 injection of 20-25 mg)
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc)	Maximum of 3 injections Maximum of 3 units (1 unit = 1 injection of 16 mg)

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.18	Osteoarthritis, localized, primary, other specified sites.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.28	Osteoarthritis, localized, secondary, other specified sites
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.38	Osteoarthritis, localized, not specified whether primary or secondary, other specified sites.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.
715.98	Osteoarthritis, unspecified whether generalized or localized, other specified sites.

- The injectable drugs must be billed after all injections are completed. The drugs are billed as a maximum of 5 units for Hyalgan or a maximum of 3 units for Synvisc (per knee).
- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan or 3 injections for Synvisc.
- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, MAA limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although these memoranda were superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J0637	Caspofungin acetate	117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02 or V25.3 or V25.49 or V25.9. (contraceptive mgmt) Males-diagnosis must be related to cancer
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585(chronic renal failure)
J2324	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585 (chronic renal failure)
J2916	Na ferric gluconate complex	585 (chronic renal failure)
J3420	Vitamin b12 injection	123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24
J3465	Injection, voriconazole	117.3 (aspergillosis)
J3487	Zoledronic acid	198.5, 203.00-203.01, and 275.42 (hypercalcemia)
J9041	Bortezomib injection	203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Suc inj interferon beta 1-a	340 (multiple sclerosis)
Q4077	Treprostinil, 1 mg	416.0-416.9 (chronic pulmonary heart disease)

Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174.0-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

Clozaril Case Coordination

- Providers must bill for Clozaril case coordination using CPT code 90862 (pharmacologic management).
- MAA reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case coordination.
- MAA reimburses providers for one unit of Clozaril case coordination per week.
- MAA reimburses providers for Clozaril case coordination when billed with ICD-9-CM diagnosis codes 295.00 – 295.9 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case coordination.

Botulism Injections **(HCPCS code J0585 and J0587)**

MAA requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**.

MAA approves Botulism injections with prior authorization:

- For the treatment of:
  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

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